

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (832)

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Laurel  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 yearsHospital, institution, or street address where death occurred:  
District Training SchoolHow long in hospital or institution? 17 years

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County .....City or town Lincolnia  
(If outside city or town limits, write RURAL and give nearest town)Street No. Alexandria - Route 3  
(If rural, give LOCATION)

2.(a) If veteran, name war..... ✓

## 3. (a) FULL NAME

Mary Anderson

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

Dec. 5, 1907

## 8. AGE:

Years

Months

Days

If less than one day

37719

..... hrs.

..... min.

9. Birthplace Bluemont, Virginia

(Town, county, and state)

10. Usual occupation Inmate11. Industry or business Institution12. Name Burns Anderson13. Birthplace Bluemont, Virginia14. Maiden name Jesse ---15. Birthplace Bluemont, Virginia16. Informant Records of District Training SchoolAddress Laurel, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof July 25, 1945  
(month) (day) (year)Cemetery or crematory CemeteryLocation District Training School

## 18. Funeral director

Address Laurel19. July 25 - 43  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 19 45, at 5 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 1 19 41, to July 24 19 45and that I last saw him/her alive on July 23 19 45

Immediate cause of death.....

Epileptic convulsion

DURATION

15 min.Due to Organic brain diseaseLifeDue to Congenital hemangiomaLifeOther conditions Left hemiplegia, hemangioma  
of face, epilepsy, imbecility.Life

(Include pregnancy within 3 months of death)

Major findings of operations..... None

..... Date of op. ....

Autopsy results..... None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

## 23. SIGNATURE

Alan M. Drummond  
D.T.S., Laurel, Md.

M. D. or other

Address..... Date signed 7-24-45

REC

AUG 8 1945

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06655

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

### 1. PLACE OF DEATH:

County Brown  
City or town near Riviera Beach (Kent main)  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Several hours

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4114 Fourth St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Mary Alice Anglin

### 3. (b) Social Security Number

#### 4. Sex

Female

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

single

### 6. (b) Name of husband or wife

#### 7. Birth date of deceased (mo., day, yr.)

July 4, 1925

#### 6. (c) If alive, give age years

#### 8. AGE:

Years 19

Months 0

Days 7

If less than one day

hrs. 0

min. 0

#### 9. Birthplace

Baltimore, Maryland  
(Town, county, and state)

#### 10. Usual occupation

None

#### 11. Industry or business

None

#### FATHER

##### 12. Name

Mr. Franklin Anglin

##### 13. Birthplace

Kentucky

#### MOTHER

##### 14. Maiden name

Marquet Ables

##### 15. Birthplace

Virginia

#### 16. Informant

Mrs. Margaret Anglin

##### Address

4114 Fourth St. Brooklyn Balto Md

#### 17. (Burial, cremation, or removal. Which?)

Burial

##### Date thereof

July 14-45

##### Cemetery or crematory

Glen Haven Park Cemetery

##### Location

Glen Burnie Md

#### 18. Funeral director

Milton Schilling

##### Address

3914 S. Hanover St 25

#### 19. Date rec'd by registrar

July 12 1945

Ida M. Whitman

Registrar

### MEDICAL CERTIFICATION

#### 20. DATE OF DEATH

July 11 1945 at 12 P.M.

#### 21. I CERTIFY that death occurred on the date above stated; that I am a duly qualified physician

Post mortem Examination

#### Immediate cause of death

Drowning

#### Due to

#### Due to

#### Other conditions

(Include pregnancy within 8 months of death)

#### Major findings of operations

#### Date of op.

#### Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

#### 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7-11-45

Where did injury occur? near Kent main Beach, B.A. Maryland  
(City or town) (County) (State)

#### Injured at home, farm, industry, public place (where?)

At sea

#### Means of injury

Drowning

#### Injured at work?

no

#### 23. SIGNATURE

John M. Caffey, M.D.

M. D. or other

#### Address

Annapolis Md

Date signed 7-11-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 25 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (934)

## CERTIFICATE OF DEATH

Reg. Dist. No. 66590

## I. PLACE OF DEATH:

County Anne Arundel  
 City or town Lothian  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 20 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind. County B.A.  
 City or town Lothian  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION) \_\_\_\_\_  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Alice Olga Armstrong

## 3. (b) Social Security Number

no

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced MARRIED

6. (b) Name of husband or wife Lawson Armstrong

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Nov 23, 1875

8. AGE: Years 69 Months 11 Days 2 hrs. \_\_\_\_\_ min. \_\_\_\_\_

9. Birthplace Calvert Co. Ind.  
(Town, county, and state)10. Usual occupation House work

11. Industry or business \_\_\_\_\_

12. Name Joseph Ward13. Birthplace Calvert Co. Ind.14. Maiden name Marquis15. Birthplace Calvert Co. Ind.16. Informant Raymond ArmstrongAddress Lothian Ind.17. Burial Date thereof July 24, 1945  
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory Int. Gion. Cem.Location Lothian Ind.18. Funeral director B. C. Standish & SonAddress Salisbury Ind.19. 7/24 45 W. Clayton  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1945 at 3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18 1945 to July 22 1945 and that I last saw him alive on July 20 1945

Immediate cause of death hypertensive pneumonia

DURATION

SenilityDue to chronic myocarditis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Emily H. Wilson, M.D. M. D. or otherAddress Lothian, Ind. Date signed 7/22/45

RECEIVED

JUL 25 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

06657

28

## 1. PLACE OF DEATH:

County Anne Arundel County  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 yrs, 3 mos, 13 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 3 yrs., 3 mos., 13 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County \_\_\_\_\_  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1827 McCulloh Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

BARNES - LEON

## 3. (b) Social Security Number

unknown

4. Sex male 5. Color or race black 6. (a) Single, married, widowed, or divorced single  
 B. (b) Name of husband or wife \_\_\_\_\_  
 6. (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 1922  
 8. AGE: Years 23 Months unknown Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Odd Jobs  
 11. Industry or business unknown  
 12. Name Arthur Barnes  
 13. Birthplace unknown  
 14. Maiden name Millie ?  
 15. Birthplace Maryland

16. Informant Hospital Records  
 Address Crownsville, Maryland  
 17. Buried Date thereof July 27, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Arbutus Cemetery  
 Location Baltimore County  
 18. Funeral director Mrs. Geo. H. Holland  
 Address 1631 Druid Hill Ave., Balto. Md.  
 19. 7/26 1945 R.W. Holland  
 (Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1945 at 12:40 P  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 10, 1942 to July 23 1945  
 and that I last saw h. im alive on July 23 1945  
 Immediate cause of death Lung Tuberculosis DURATION Known to us since 7/17/45  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions Schizophrenia - Paranoid Type Known to us since 4/10/42  
 (Include pregnancy within 3 months of death)  
 Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE [Signature] M. D. or other [Signature]  
 Address Crownsville, Maryland Date signed 7/23/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MD

## CERTIFICATE OF DEATH

06658 P.

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County... Anne Arundel  
 City or town... New Beachwood from Pasadena, PD.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hour

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Samuel Boozef (Samuel D. Boozef)

3. (b) Social Security Number

4. Sex

male

5. Color or race

negro

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife.

7. Birth date of

deceased (mo., day, yr.)

April 28, 1927

8. AGE:

18

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Baltimore City, Md  
(Town, county, and state)

10. Usual occupation

laborer

11. Industry or business

produce

12. Name

Samuel Boozef

13. Birthplace

unknown

14. Maiden name

not known

15. Birthplace

unknown

16. Informant

Mrs. Levenia Butler

Address

1102 N. Wolfe St. Baltn. Md17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

Aug. 7, 1945  
(month) (day) (year)

Cemetery or crematory

St. Calvary

Location

Robert H. Young Jr.

18. Funeral director

804 N. Caroline St.

Address

19. July 31

(Date rec'd by registrar)

19 45A.W. Hedrick  
a.e.s.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

922 Rutland Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 3019 45

at

1:45 P.M.21. I CERTIFY that death occurred on the date above stated; that it was not caused byPost mortem Examination

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Accident

Date of

7-30-45

Where did injury occur

New Beachwood Grove, A.A. Maryland

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Thurgood Marshall

Means of injury

Capuzed Cause

Injured at work?

No

23. SIGNATURE

John M. Coffey, M.D.

M. D. or Other

Address

Annapolis MdDate signed 7-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06659

★ Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel Co.

County

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 59 yrs.

Hospital, institution, or street address where death occurred:

10 Morris St. Annapolis Md.

How long in hospital or institution? \*\*\*\*\*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland

County: A. A. Co.

City or town: Annapolis Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 10 Morris St.

(If rural, give LOCATION)

2.(a) If veteran, name war.

None

3. (a) FULL NAME

Joseph Brown

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ida Brown

7. Birth date of

deceased (mo., day, yr.)

January 22, 1886

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

59

59

7

hrs.

min.

9. Birthplace

Annapolis Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

None

MOTHER FATHER

12. Name

Joseph Brown

13. Birthplace

A. A. Co.

14. Maiden name

Catherine Ross

15. Birthplace

A. A. Co.

16. Informant

Mrs Ida Brown

Address

10 Morris St. Annapolis Md.

17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

Burial

Date thereof

8/3/45

(month) (day) (year)

Brew Hill Cemetery

West St. Ext. Annapolis Md.

18. Funeral director

Mrs Charles E. Hicks

Address

45 Northwest St. Annapolis Md.

19.

(Date rec'd by registrar)

August 3, 45

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 31, 1945

at

8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 26, 1945

to

July 31, 1945

and that I last saw him alive on

July 31, 1945

Immediate cause of death

Heart, lungs, kidneys

DURATION

Due to

Due to

Other conditions

Chronic hepatitis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. R. L. Richardson

M. D. or other

Address

Annapolis, Md.

Date signed

8/2/45

RECEIVED  
AUG 4 1945  
BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 806 BC

## CERTIFICATE OF DEATH

Reg. Diat. No. ....

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr. 11 mos. 11 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 1 yr. 11 mos. 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County -----  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 403 North Parrish Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -----

## 3. (a) FULL NAME

BROWN - MELVIN

## 3. (b) Social Security Number

4. Sex male 5. Color or race black 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife -----6.(c) If alive, give age ----- years7. Birth date of deceased (mo., day, yr.) March 26, 1935

8. AGE: Years 10 Months 4 Days 1 If less than one day --- hrs. --- min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation none11. Industry or business -----

FATHER 12. Name unknown  
 13. Birthplace unknown

MOTHER 14. Maiden name Lillian Brown (?)  
 15. Birthplace Maryland

16. Informant Hospital Records  
 Address Crownsville, Maryland

17. Burial Date thereof 7/30/45  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Mt Auburn Cem.Location Balt. Md.18. Funeral director Chas. HooperAddress 5127 N. Carrollton Ave.

19. 7/30 19 45  
 (Date rec'd by registrar) Registrar A

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 19 45 at 7:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 16 19 43 to July 27 19 45  
 and that I last saw him alive on July 27 19 45

Immediate cause of death Encephalitis DURATION Known to us since  
8/16/43

Due to Lead PoisoningDue to -----

Other conditions Idiocy Known to us since 8/16/43  
 (Include pregnancy within 8 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ----- Date of -----

Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE Walter V. Smith M. D. or otherAddress Crownsville, Maryland Date signed 7/27/45

MARGIN RESERVED FOR BINDING

VS A15

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066608

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

## 1. PLACE OF DEATH:

County Anna Arundel  
 City or town Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Margaret J. Campbell

## 3. (b) Social Security Number

4. Sex

female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife

William J. Campbell

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

January 24, 1864

8. AGE:

Years

Months

Days

If less than one day

8158

hrs.

min.

9. Birthplace

Pennsylvania  
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Allen Bell

13. Birthplace

England

MOTHER

14. Maiden name

Jane Elliott

15. Birthplace

England

16. Informant

Margaret J. Davenport

Address

4016 Ritchie Highway

17. Burial, cremation, or removal, Which?

Burial

Date the body

July 5, 1945  
(month) (day) (year)

Cemetery or crematory

Flem Haven

Location

Flem Burnie, Md.

18. Funeral director

John F. Denny, Inc.

Address

715 Light St.

19.

(Date rec'd by registrar)

19.45

D. W. Sedrail  
D. M.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Md.

County

Anna Arundel

City or town

Brooklyn

(If outside city or town limits, write RURAL and give nearest town)

Street No.

4016 Ritchie Highway

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 2,

19.45

at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 29

19.45

to July 2

19.45

and that I last saw him alive on

July 2nd

19.45

Immediate cause of death

coronary thrombosis

DURATION

June 29

Due to

Arterio-sclerosis  
Cardio-vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Carl L. Lerner - M.D.

M. D. or other

Address

320 Annapolis

Date signed

7/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County aa Co.City or town Barbersville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

WILLIAM EDWARD CARR

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced M6. (b) Name of husband or wife FLORENCE HUBBARD

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) June 26-18738. AGE: Years 72 Months 1 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Harford Co. Md.  
(Town, county, and state)10. Usual occupation Locomotive Eng11. Industry or business Penna R.R.12. Name Frank13. Birthplace Harford Co. Md.14. Maiden name Mary Carr15. Birthplace Harford Co. Md.16. Informant WifeAddress Barbersville aa Co. Md.17. Burial Date thereof 8/2/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory MeadowdaleLocation Wash Blvd.18. Funeral director Clarence F. HoffmanAddress 1639 N. Broadway19. 8/45  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County aa Co. MdCity or town Barbersville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 7 - Portland Rd  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 19 45 at 4:55 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 8 19 45 to July 30 19 45and that I last saw him alive on July 27 19 45

Immediate cause of death \_\_\_\_\_

DURATION

Acute Sclerosis (7)

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE W. J. HoffmanAddress Barbersville Date signed 7/31/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

Reg. Dist. No. 06663 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Annapolis, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months  
 Hospital, institution, or street address where death occurred:  
Mill Creek, Annapolis, Md.  
 How long in hospital or institution? admitted lead to base

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State La Louisiana County \_\_\_\_\_  
 City or town Basile, Pt #1, RN 246  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2(a) If veteran, name war World War #2 ✓

## 3. (a) FULL NAME

Nelson DeClues

## 3. (b) Social Security Number

Ser. no 977-98-40

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male Negro Single

6. (b) Name of husband or wife.

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 5-2-26

8. AGE: Years Months Days If less than one day  
19 2 5 \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Basile, Louisiana  
 (Town, county, and state)

10. Usual occupation Navy Stewards Mate

11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Ellen DeClues15. Birthplace Unknown16. Informant Bureau Mercers RecordsAddress Annapolis, Md.

17. Removal Date thereof 7-10-45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory UnknownLocation Basile, La.18. Funeral director Box 5 HoppingAddress West Street, Annapolis, Md.19. July 10, 1945 7:15 PM

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945 at 3:40 P.M.21. I CERTIFY that death occurred on the date above stated: Post mortem ExaminationJuly 7, 1945Immediate cause of death Drowning

DURATION

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7/7/45Where did injury occur? near Annapolis, Md. (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Mill CreekMeans of injury Drowning Injured at work? NoSignature John M. Claffy M.D. DeputyAddress Annapolis, Md. M. D. or otherDate signed 7/7/45

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUL 13 1945  
BUREAU V.E.

RECEIVED JUL 13 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

66664

Reg. Dist. No. 23922

### 1. PLACE OF DEATH:

County Anne Arundel

City or town Odenton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Prince Georges

City or town Hyattsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1400  
(If rural, give LOCATION)

2. (a) If veteran, name war

### 3. (a) FULL NAME

Dorothy Virginia Disney

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Dr. C. Disney

7. Birth date of deceased (mo., day, yr.) Oct. 15 - 1875

8. (c) If alive, give age 73 years

8. AGE: Years 69 Months 9 Days 11 If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Joseph Baldwin

13. Birthplace Maryland

14. Maiden name Julia A. Conway

15. Birthplace Maryland

16. Informant My A. J. Disney

Address Odenton, Md.

17. Burial Bethel Date thereof 7/28/45  
(Burial, cremation, or removal. Which) (month) (day) (year)

Cemetery or crematory Bethel

Location Phippes & Meade - Md.

18. Funeral director Lloyd Harris

Address 381 Main St., Laurel Md.

19. July 28, 45 Core E. Kachler  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 45 at 3:25 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 7 19 40 to July 25 19 43

and that I last saw him alive on July 25 19 40

Immediate cause of death cardiac failure

DURATION

Due to nephritis, with

Due to Bright's

Other conditions neurosis of tissues

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thomas Newman MD

M. D. or other

Address Millersville Md. Date signed 7/28/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

County  
COPY SENT TO ~~LOCAL~~ REGISTRAR NO. \_\_\_\_\_ DATE 8/2/45

CERTIFICATE OF DEATH

ISSUED BY THE DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1624

## CERTIFICATE OF DEATH

06665

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County Prince George's  
 City or town Landover  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1-100 hours  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Brooklyn 25th R.F.D. #9-B.27  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Norsey Road  
 (If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Summerfield C. Diney

## 3. (b) Social Security Number

Unknown

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced W.

6. (b) Name of husband or wife Cora C. Diney

7. Birth date of deceased (mo., day, yr.) December 20 - 1867  
 6. (c) If alive, give age 65 years

8. AGE: Years 77 Months 6 Days 20 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mt. Vernon, Baltimore Co. Md.  
 (Town, county, and state)

10. Usual occupation Laborer11. Industry or business G. County Road Repair Crew12. Name John Wesley Diney13. Birthplace Maryland14. Maiden name Susan Harrison15. Birthplace Virginia16. Informant Mrs. S. C. DineyAddress Brooklyn 25th R.F.D. #9-B.2717. Burial Date thereof 7/21/45

(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory FriendshipLocation Front Meade Rd. - G. Co. - Md.18. Funeral director Thomson Co. LexingtonAddress 141 Glen Burnie, Md.19. July 20 19 45 Markella

(Date recd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 45 at 1:36 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death Heart failure DURATION Sudden

Due to Senility

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

\_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Kustave H. Paecher MDAddress 141 Glen Burnie, Md. Date signed 7/19/45

RECEIVED  
JUL 24 1945  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 307

## CERTIFICATE OF DEATH

06666

Reg. Dist. No. 6428

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 months, 20 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 3 months, 20 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Dorchester  
City or town Vienna  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Cambridge Road  
(If rural, give LOCATION)  
No  
2.(a) If veteran, name war

### 3. (a) FULL NAME

DOCKINS - LAURENCE E.

3. (b) Social Security Number  
213-24-4776

4. Sex male 5. Color or race black 6.(a) Single, married, widowed, or divorced married  
6.(b) Name of husband or wife Pauline Dockins.  
Vienna, Maryland 6.(c) If alive, give age 30 years  
7. Birth date of November 16, 1907  
deceased (mo., day, yr.)  
8. AGE: Years 37 Months 7 Days 17 If less than one day  
-----hrs. -----min.

9. Birthplace Sussex County, Delaware  
(Town, county, and state)  
10. Usual occupation laborer  
Factory  
11. Industry or business  
FATHER 12. Name John Dockins  
13. Birthplace Dorchester County, Md.  
MOTHER 14. Maiden name Maria Farrare  
15. Birthplace Dorchester County, Md.

16. Informant Hospital Records  
Address Crownsville, Maryland  
17. Burial Date thereof July 8, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Mount Nebo Cemetery  
Cemetery or crematory  
Location Near Sharptown, Maryland  
18. Funeral director J. J. Frampton & Son  
Address Federalburg, Maryland  
19. July 4 1945 J. J. Frampton  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 11:10 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 13 1945, to July 3 1945  
and that I last saw him alive on July 3 1945

Immediate cause of death General Paresis DURATION Known to us since 3/20/45  
-----  
Due to -----  
-----  
Due to -----  
Other conditions -----

(Include pregnancy within 3 months of death)  
Major findings of operations ----- Date of op. -----  
Autopsy results -----  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ----- Date of -----  
Where did injury occur? -----  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) -----  
Means of injury ----- Injured at work? -----  
23. SIGNATURE [Signature] M. D. or other  
Crownsville, Maryland Date signed 7/3/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 13 1945  
BUREAU T.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

## CERTIFICATE OF DEATH

Reg. Dist. No. 06667 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town St. Margarets  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town St. Margarets  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

William Henry Doyle

## 3. (b) Social Security Number

4. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Married6.(b) Name of husband or wife Helen J. Doyle

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Oct 29<sup>th</sup> 19008. AGE: Years 44 Months 8 Days 18

If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Phila Pa  
(Town, county, and state)10. Usual occupation Retired Captain U. S. MC11. Industry or business Marines Corps12. Name James J. Doyle13. Birthplace Pa.14. Maiden name Katharine Donovan15. Birthplace Pa.16. Informant Helen J. DoyleAddress St Margarets Q of G Md17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20<sup>th</sup> 1945  
(month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington Va18. Funeral director John M. TaylorAddress Annapolis Md.19. July 20 19 45 7:15 PM  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 45 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 21 19 45 to June 30 19 45and that I last saw him alive on June 30 - 1945Immediate cause of death Coronary thrombosisDue to Angina PectorisDue to Coronary arterio sclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations. none

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. no Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE R. H. Harris - Lt Col (R) USNRAddress USN Hospital, Annapolis M. D. or other \_\_\_\_\_Date signed 7-19-45

RECEIVED

JUL 21 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06668

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County a aCity or town annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

4 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a aCity or town Davidsonville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Frank H. Duckett

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Oliver L. Duckett

7. Birth date of

deceased (mo., day, yr.)

Feb 21 -1858

6. (c) If alive, give age .....

years

8. AGE:

Years

Months

Days

If less than one day

87415

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

FATHER

12. Name

Francis H. Duckett

13. Birthplace

Maryland

MOTHER

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

Address

Blairdene DuckettDavidsonville, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

July 9/45  
(month) (day) (year)

Cemetery or crematory

St. L. Cemetery

Location

Davidsonville, Md

18. Funeral director

B. I. Hopkins

Address

annapolis, Md19. July 919. 45

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 19 45 at 10:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec19 43 to July 6 19 45and that I last saw him alive on July 6 19 45

Immediate cause of death

uremia

DURATION

2 days

Due to

arteriosclerotic cardiovascularrenal disease157.1.21

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

S. Bussch

M. D. or other

Address

annapolis, MdDate signed 7/21/45

RECEIVED  
JUL 11 1945  
BUREAU OF A. P.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

06669

## CERTIFICATE OF DEATH



Reg. Dist. No. 26

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Sehunchton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State MD. County A. A.  
 City or town Sehunchton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3.(a) FULL NAME

Daniel Fountain  
 4. Sex Male 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

## 3.(b) Social Security Number

6.(b) Name of husband or wife Marie Fountain  
unknown. 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) 1867

8. AGE: Years 78 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Sehunchton Md  
 (Town, county, and state)

10. Usual occupation oysterman

11. Industry or business \_\_\_\_\_

12. Name Daniel Fountain

13. Birthplace Sehunchton

14. Maiden name Blunt

15. Birthplace Md

16. Informant Luther Fountain

Address Sehunchton Md

17. Burial Date thereof July 15-1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Franklin Mem.

Location Sehunchton Md

18. Funeral director H.A. Hurdick & son

Address Salisbury Md.

19. July 15-45 19 45 D.B. Dent  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 45, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 45 to July 10 19 45

and that I last saw him alive on July 1 19 45

Immediate cause of death cerebral hemorrhage

Due to hypertension

Due to arteriosclerosis

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Emily H. Wilson, M.D.

Address Salisbury, Md. Date signed 7/14/45

RECEIVED  
JUL 17 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06670

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 29 yrs. 8 mos. 22 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 29 yrs. 8 mos. 22 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -----  
City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 1511 or 1513 Mount Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war unknown

## 3. (a) FULL NAME

GREEN - JOHN

## 3. (b) Social Security Number

4. Sex <u>male</u>	5. Color or race <u>black</u>	6.(a) Single, married, widowed, or divorced <u>married</u>
6.(b) Name of husband or wife <u>Ida Green</u>		
6.(c) If alive, give age <u>unk.</u> years		
7. Birth date of deceased (mo., day, yr.) <u>1877</u>		
8. AGE: Years <u>68</u>	Months <u>unknown</u>	Days <u>unknown</u> If less than one day .....hrs. ....min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation Laborer  
unknown  
11. Industry or business

FATHER	12. Name <u>unknown</u>
	13. Birthplace <u>unknown</u>
MOTHER	14. Maiden name <u>unknown</u>
	15. Birthplace <u>unknown</u>

16. Informant Hospital Records  
Address Crownsville, Maryland  
17. Buried Mt. Auburn Cemetery Date thereof July 25, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Baltimore, Maryland  
Location Mrs. Hemsley  
18. Funeral director Mrs. Hemsley  
Address 578 W. Biddle St., Balto., Md.  
19. 7/23 45 E. F. Joyce  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 45, at 7:00 P. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 29 19 15 to July 21 19 45.  
and that I last saw h. im alive on July 21 19 45.

Immediate cause of death <u>Chronic Myocarditis</u>	DURATION Apprx. <u>10 mos.</u>
Due to <u>-----</u>	
Due to <u>-----</u>	
Other conditions <u>Dementia Praecox</u>	Apprx. <u>30 yrs.</u>

(Include pregnancy within 3 months of death)

Major findings of operations -----  
Date of op. -----  
Autopsy results -----  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide ----- Date of -----  
Where did injury occur? -----  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) -----  
Means of injury ----- Injured at work? -----  
23. SIGNATURE [Signature] M. D. or other -----  
Address Crownsville, Maryland Date signed 7/21/45

RECEIVED  
JUL 25 1946  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

06671

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. Conduit Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Anna Selman Hackett

## 3. (b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed

## 6. (b) Name of husband or wife

William T. Hackett

## 6. (c) If alive, give age..... years

## 7. Birth date of

deceased (mo., day, yr.)

May 28, 1889

## 8. AGE:

56 Years

Months

1

Days

18

If less than one day

hrs.

min.

## 9. Birthplace

Annapolis, Md.  
(Town, county, and state)

## 10. Usual occupation

house wife

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

## 13. Birthplace

## 14. Maiden name

## 15. Birthplace

## 16. Informant

## Address

## 17.

(Burial, cremation, or removal to)

Date thereof

July 19, 1945  
(month) (day) (year)

## Cemetery or crematory

St. Anne's Cemetery

## Location

Annapolis, Md.

## 18. Funeral director

## Address

John W. Taylor  
Annapolis, Md.

## 19.

(Date rec'd by registrar)

July 18, 1945  
John W. Taylor  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 45, at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 19 44 to July 16 19 45and that I last saw him alive on July 16 19 45

## Immediate cause of death

acute Myocardial Infarction

## DURATION

6 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Georg C. Boal

M. D. or other

Address

Annapolis, Md.Date signed 7-18-45

CERTIFICATE OF DEATH

1. Full Name of Deceased

Robert H. Smith

Robert H. Smith

2. Date of Death

RECEIVED  
JUL 19 1945  
BUREAU V.S.

JUL 19 1945

BUREAU V.S.

UNITED STATES DEPARTMENT OF HEALTH

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply exact item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

06672

Reg. Dist. No. 20

## 1. PLACE OF DEATH:

County... Anne Arundel  
 City or town... Harmond, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 years  
 Hospital, institution, or street address where death occurred:  
in  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Anne Arundel  
 City or town... Harmond  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Floyd Hanley  
 4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

## 3. (b) Social Security Number

NONE6.(b) Name of husband or wife Nancy Elizabeth Hanley6.(c) If alive, give age 58 years7. Birth date of deceased (mo., day, yr.) Nov. 21, 1886

8. AGE: Years 58 Months 8 Days 23 If less than one day  
 .....hrs. ....min.

9. Birthplace... Shellina, Missouri  
 (Town, county, and state)10. Usual occupation... Engineer, manager

## 11. Industry or business

12. Name... William H. Hanley13. Birthplace... Missouri14. Maiden name... Allen Finley15. Birthplace... Missouri16. Informant... Mrs Nancy Elizabeth HanleyAddress... Harmond, Md.17. Disposal (Burial, cremation, or removal. Which?) Burial Date thereof... July 17 1945  
 (month) (day) (year)Cemetery or crematory... Arlington National CemeteryLocation... Arlington, Va.18. Funeral director... A. Hines Co.Address... 2901-1407 N.W. Washington St.19. 7/15 1945 W. H. Clayton  
 (Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... July 15 1945, at 9.9 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 1945, to July 15 1945and that I last saw him alive on not at all 19.....

Immediate cause of death

coronary thrombosis

DURATION

Due to arteriosclerosis

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Emil H. Wilson

M. D. or other

Address... Saltzman, Md. Date signed... 7/15/45

RECEIVED  
JUN 20 1965  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06673

9

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County A. A. Co.

City or town Jessups

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Old Annapolis Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Jessups

(If outside city or town limits, write RURAL and give nearest town)

Street No. Old Annapolis Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARY E. HARMAN

## 3. (b) Social Security Number

213-03-0497

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

Widow

6. (b) Name of husband or wife Walter H. Harman

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Nov. 12, 1878

8. AGE:

Years

Months

Days

If less than one day

66

8

4

hrs.

min.

9. Birthplace Balto., Md.

(Town, county, and state)

10. Usual occupation

Teacher

11. Industry or business

Hilltop School

FATHER

12. Name Samuel Jones

13. Birthplace Balto., Md.

14. Maiden name Elizabeth -

15. Birthplace --

16. Informant Mr. Walter S. Harman

Address Old Annapolis Rd., Jessups, Md.

17.

Burial

Date thereof

7/19/45

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Meadowridge Cem.

Location

Wash. Blvd., Md.

18. Funeral director WM. J. TICKNER &amp; SONS

Address

Balto., Md.

19.

7/18/45

X5

A. W. Medical  
Jm. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July - 16

19. X5 at 7:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-21-

19. 44

to July 16 19. X5

and that I last saw him alive on July 16 19. X5

Immediate cause of death

DURATION

Carcinoma - Kidney

Due to

Primary in kidney

Due to

Duration: One year

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. W. Medical  
Jm. Registrar

M. J. Registrar

Address

Date signed

7/17/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

## CERTIFICATE OF DEATH

Reg. Dist. No. 06674

## 1. PLACE OF DEATH:

County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For new born infants give residence of mother)  
 State.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Noah Hazard

## 3. (b) Social Security Number

None

4. Sex.....  
 5. Color or race.....  
 6.(a) Single, married, widowed, or divorced.....

6.(b) Name of husband or wife.....  
 6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.).....  
 8. AGE: Years..... Months..... Days..... hrs..... min.....

9. Birthplace.....  
 (Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....  
 Address.....

17. Date thereof.....  
 (Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemetery or crematory.....  
 Location.....

18. Funeral director.....  
 Address.....

19. Date rec'd by registrar.....  
 (Date rec'd by registrar).....

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from.....  
 and that I last saw..... alive on.....

Immediate cause of death.....  
 DURATION.....

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE.....  
 Address.....

24. Date signed.....

RECEIVED

JUL 11 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

06675

## CERTIFICATE OF DEATH



Reg. Diat. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
City or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 8 days  
Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
How long in hospital or institution? 8 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Howard  
City or town Sykesville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. unknown  
(If rural, give LOCATION)  
2.(a) If veteran, name war unknown

## 3. (a) FULL NAME

HOWARD - WILLIAM

## 3. (b) Social Security Number

unknown

4. Sex male 5. Color or race black 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife unknown7. Birth date of deceased (mo., day, yr.) 1882 6.(c) If alive, give age ----- years

8. AGE: Years 63 Months unknown Days ----- If less than one day ----- hrs. ----- min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation Laborer11. Industry or business unknown12. Name Henry Howard13. Birthplace Maryland14. Maiden name Louise Norris15. Birthplace Maryland16. Informant Hospital RecordsAddress Crownsville, Maryland17. Buried Date thereof July 26, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory West LibertyLocation Howard County, Maryland18. Funeral director Robert L. SnowdenAddress Rockville, Maryland19. July 23 19 45 E F Joyce Lane  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 45, at 9:15P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 19 45 to July 22 19 45 and that I last saw h. im alive on July 22 19 45.Immediate cause of death General Arteriosclerosis DURATION Prior to 7/14/45Due to -----Due to -----Other conditions Senile Psychosis - Known to Confused & Delirious Type us since 7/14/45  
(Include pregnancy within 3 months of death)Major findings of operations -----Date of op. -----Autopsy results -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----Where did injury occur? ----- (City or town) (County) (State)Injured at home, farm, industry, public place (where?) -----Means of injury ----- Injured at work? -----23. SIGNATURE [Signature] M. D. or otherAddress Crownsville, Maryland Date signed 7/22/45

RECEIVED

JUL 25 1945

BUREAU V. G.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Prince Georges  
 City or town Stoney Creek Beach  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Five minutes  
 Hospital, institution, or street address where death occurred:  
Stoney Creek  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County St. Anne  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 235 - E. Grindall St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

James Jenkins

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Dec. 22, 1942

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

2

6

8

hrs.

min.

9. Birthplace

Baltimore, Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

William Jenkins

13. Birthplace

Baltimore, Md.

14. Maiden name

Annabel Solomon

15. Birthplace

Baltimore, Md.

16. Informant

Mr. W. Jenkins

Address

235 - E. Grindall St.

17.

(Burial, cremation, or removal. Which?)

Date thereof

July 4, 1945  
(month) (day) (year)

Cemetery or crematory

Cedar Hill

Location

Kitchie Highway

18. Funeral director

John F. O'Connell, Inc.

Address

715 Light St.

19.

(Date received by registrar)

July 3, 1945

M. DeAlba  
Registral

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 1st 1945, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

Accidental Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

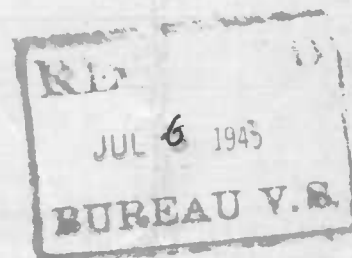
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 7/1/45Where did injury occur? Stoney Creek Beach (City or town) St. Anne (County) Md. (State)Injured at home, farm, industry, public place (where?) Stoney CreekMeans of injury Drowning Injured at work? No

23. SIGNATURE

Gustave P. Anderson M. D. or other  
Address Stoney Creek, Md. Date signed 7/3/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

## CERTIFICATE OF DEATH

06677

★ 22  
Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Anne Arundel County  
 City or town Laurel, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year  
 Hospital, institution, or street address where death occurred:  
District Training School  
 How long in hospital or institution? 1 year

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ..... County .....  
 City or town Washington, D. C.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1454 Que Street, N. W.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ..... ✓

## 3. (a) FULL NAME

Bertha Johnson

## 3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife .....  
 6.(c) If alive, give age ..... years  
 7. Birth date of deceased (mo., day, yr.) February 18, 1942  
 8. AGE: Years Months Days If less than one day  
3 5 8 ..... hrs. .... min.

9. Birthplace Louisa County, Virginia  
 (Town, county, and state)  
 10. Usual occupation Inmate  
 11. Industry or business Institution  
 12. Name Clad Broadus  
 13. Birthplace Virginia  
 14. Maiden name Merdell Johnson  
 15. Birthplace Pennsylvania

16. Informant Records of District Training School  
 Address Laurel, Maryland

17. Date thereof 7-23-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Wash. DC  
 Location .....

18. Funeral director Dr. F. Allen  
 Address 1326-V St N.W.

19. Date rec'd by registrar July 26 19 45 Registrar Isaiah Bailey

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 19 45, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 10 19 44 to July 26 19 45  
 and that I last saw her alive on July 25 19 45

Immediate cause of death Broncho pneumonia  
 DURATION 3 days

Due to .....

Due to .....

Other conditions Organic brain disease,  
congenital, with microcephaly,  
idiocy, epilepsy. none  
 (Include pregnancy within 8 months of death)  
 Major findings of operations.....

Date of op. ....

Autopsy results none  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE Alan M. Drummond, M.D.  
 Address D.T.S., Laurel, Md. Date signed 7/26/45

RECEIVED  
AUG 8 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d BC

## CERTIFICATE OF DEATH

Reg. Diat. No. 28

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Crownsville, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 month, 20 days

Hospital, institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 1 month, 20 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County -----City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1928 Division Street  
(If rural, give LOCATION)

2.(a) If veteran, name war -----

## 3. (a) FULL NAME

JOHNSON - EMMA C.

## 3. (b) Social Security Number

-----

## 4. Sex

Female

## 5. Color or race

black

## 6. (a) Single, married, widowed, or divorced

widow

B. (b) Name of husband or wife -----

7. Birth date of deceased (mo., day, yr.) 1871 March 22

6. (c) If alive, give age ----- years

8. AGE: Years 74 Months 3 unknown 27 Days ----- If less than one day ----- hrs. ----- min.9. Birthplace Georgia  
(Town, county, and state)10. Usual occupation Housework

11. Industry or business -----

12. Name Albert Long13. Birthplace Georgia14. Maiden name Mathilda ?15. Birthplace Georgia16. Informant Hospital RecordsAddress Crownsville, Maryland17. Buried Date thereof July 21, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ArbutusLocation Baltimore City18. Funeral director S. W. Chase & SonsAddress 638 N. Gilmor St., Balto., Md.19. July 19, 1945 Atw. Hedrick  
(Date rec'd by registrar) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 45, at 10:45A21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 19 45 to July 18 19 45  
and that I last saw him/her alive on July 18 19 45Immediate cause of death Chronic Myocarditis Known to us since 5/28/45Due to -----  
Due to -----Other conditions Senile Psychosis Known to us since 5/28/45  
(Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----

Autopsy results -----  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ----- Date of -----

Where did injury occur? -----  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury ----- Injured at work? -----

23. SIGNATURE Atw. Hedrick M. D. or otherAddress Crownsville, Maryland Date signed 7/18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06679

Reg. Diat. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 12 yrs. 11 mos. 5 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 12 yrs. 11 mos. 5 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Annapolis  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 11 Pleasant Street  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

JOHNSON - FLORENCE (FLORINE)

## 3. (b) Social Security Number

4. Sex female 5. Color or race black 6. (a) Single, married, widowed, or divorced single

8. (b) Name of husband or wife \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.) 1911 6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 34 Months unknown Days unknown If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
 (Town, county, and state)

10. Usual occupation Chambermaid

11. Industry or business \_\_\_\_\_

12. Name Irvin Johnson13. Birthplace Maryland14. Maiden name Cora Walker15. Birthplace Maryland16. Informant Hospital RecordsAddress Crownsville, Maryland

17. burial Date thereof July 16, 45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory HospitalLocation Crownsville18. Funeral director Suph

Address \_\_\_\_\_

19. July 11, 45 19 45 27 Joyce Lora

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 19 45 at 1:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 5 19 32 to July 10 19 45

and that I last saw h. er alive on July 10 19 45

Immediate cause of death Lung Tuberculosis DURATION Known to us since 7/5/45

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Dementia Praecox Known to us since 8/5/32

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter J. Hinkle M. D. or other \_\_\_\_\_

Address Crownsville, Maryland Date signed 7/10/45

RECEIVED  
JUL 13 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 452

## CERTIFICATE OF DEATH

06680

Reg. Diat. No. 21

## 1. PLACE OF DEATH:

County A. A. ParoleCity or town Parole  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Thomas H. Johnson

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Jennil S. Johnson

7. Birth date of

deceased (mo., day, yr.)

Jan. 13 18865. (c) If alive, give age 55 years

8. AGE:

Years

Months

Days

If less than one day

39 7 1 hrs. min.

9. Birthplace

Lothian, Ind. A. A. Co.  
(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

12. Name Jennil S. Johnson

13. Birthplace

Ind.

14. Maiden name

Mary Anderson

15. Birthplace

Ind.16. Informant Jennil S. JohnsonAddress Parole, P. G.17. Burial  
(Burial, cremation, or removal. Which?)Date thereon July 17/45  
(month) (day) (year)

Cemetery or crematory

Brewer Hill

Location

Annapolis

18. Funeral director

J. B. Johnson

Address

Annapolis19. July 17 19 45

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County A. A.City or town Parole, Ind  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 19 45, at 9:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 19 45 to July 14 19 45and that I last saw him alive on July 14 19 45

Immediate cause of death

Carcinoma of lower lip

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

R. L. Richardson MD

M. D. or other

Address Annapolis Ind Date signed 7/16/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 18 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06681

Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Fort George G. Meade, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 39 days  
 Hospital, institution, or street address where death occurred:  
Regional Hospital, Ft. G. G. Meade, Md.  
 How long in hospital or institution? 39 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State GERMANY County -  
 City or town Himmelpforten 120  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. -  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

JUNGELAUS, Johannes -

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Frau Trichen Jungelaus  
 6.(c) If alive, give age Unknown  
 7. Birth date of deceased (mo., day, yr.) 8 Sept 1906  
 8. AGE: Years 38 Months 9 Days 23 If less than one day - hrs. - min.

8. Birthplace Stade, Germany  
 (Town, county, and state)  
 10. Usual occupation Prisoner of War  
 11. Industry or business -  
 12. Name Unknown  
 13. Birthplace Unknown  
 14. Maiden name Unknown  
 15. Birthplace Unknown

16. Informant P. W. Records  
 Address U. S. Army  
 17. Burial Date thereof 7/3/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Post Cemetery  
 Location Fort George G. Meade, Md.  
 18. Funeral director Howard H. Blythe, Jr.  
 Address 4914 Belair Road.  
 19. 2 July 1945  
 (Date rec'd by registrar) W. J. Dawson, Jr. 1st Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 1 July 1945 at 4:03 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 July 1945 to 1 July 1945  
 and that I last saw him alive on 1 July 1945

Immediate cause of death myocarditis, chronic  
 DURATION 4 WEEKS

Due to diphtheria 5 WEEKS

Due to -

Other conditions -

(Include pregnancy within 8 months of death)

Major findings of operations -

Date of op. -

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE E. Cohen M. D. or other

Regional Hosp. Ft. Meade, Md. Date signed 2 Jul 45

RECEIVED  
JUL 5 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

## 1. PLACE OF DEATH:

County A.A.City or town Crownsville, Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 mos. 27 days

Hospital, institution, or street address where death occurred:

Crownsville State HospitalHow long in hospital or institution? 5 mos. 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County ACity or town Betho.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1515 Penn. Av.  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Clarence Kenner (KENNER)

## 3. (b) Social Security Number

4. Sex M. 5. Color or race C. 6.(a) Single, married, widowed, or divorced widowedB.(b) Name of husband or wife Katie7. Birth date of deceased (mo., day, yr.) June 5, 18918. AGE: Years 54 Months 08 Days 1 less than one day hrs. min.9. Birthplace Betho.  
(Town, county, and state)10. Usual occupation un

11. Industry or business

12. Name unknown

13. Birthplace

14. Maiden name unknown

15. Birthplace

16. Informant Hospital RecordsAddress Crownsville, Md.17. Serial Date thereof July 7, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arbiter Mem. Pk.Location Baltimore Co., Md.18. Funeral director Mr. George W. HollandAddress 1631 Wm. Hill Ave.19. 7/6 45 Abv. Hedrick  
(Date rec'd by registrar) (Reg.) (Reg.)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 3 1945, at 12:30 p M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 8 1945 to July 3 1945 and that I last saw him alive on July 3 1945Immediate cause of death General arteriosclerosis DURATION about 6 mos.

Due to

Due to

Other conditions Psychosis w/ cerebral arteriosclerosis about 6 mos.  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

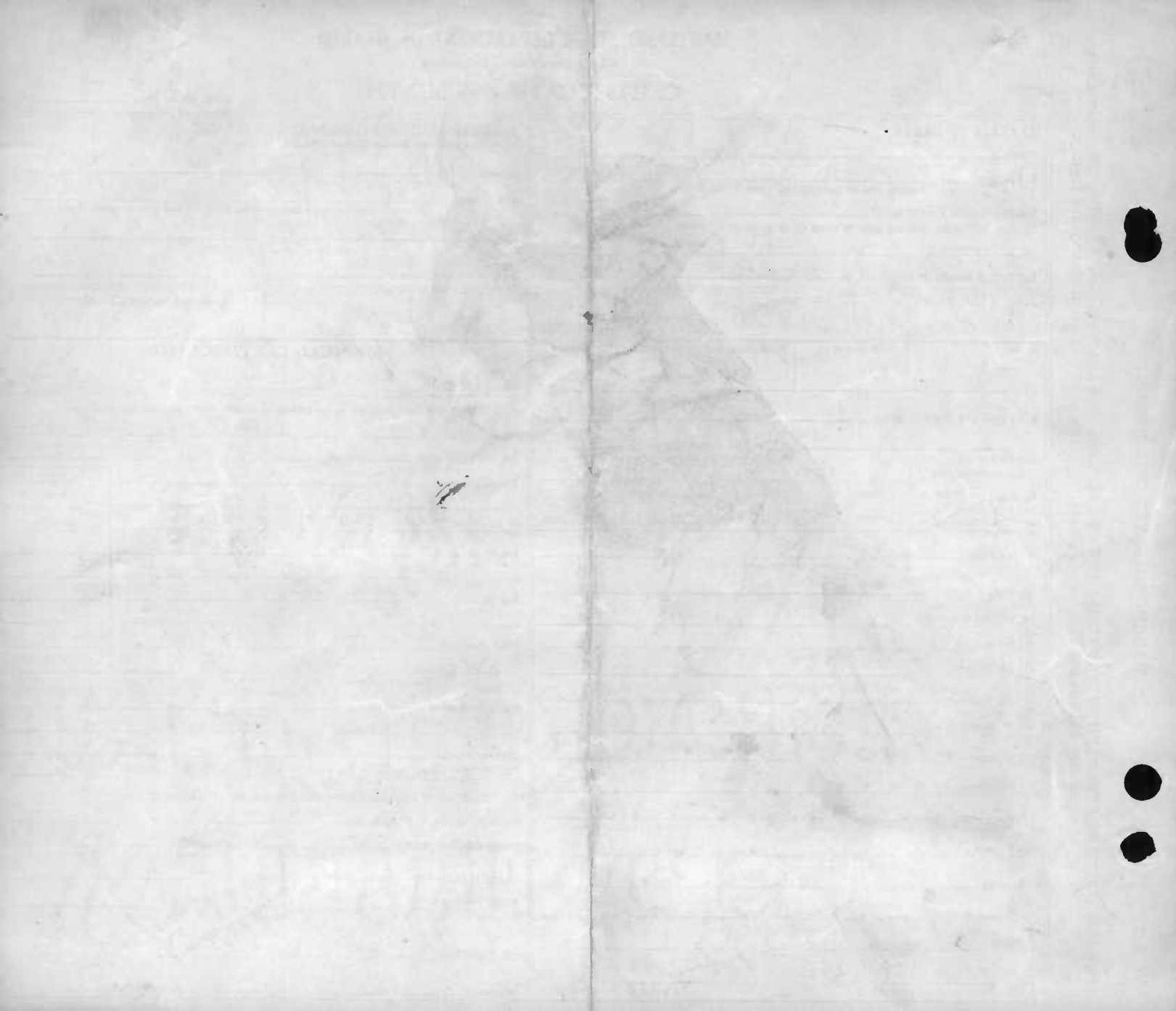
Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Heart Injured at work?23. SIGNATURE Abv. Hedrick M. D. or other

Address Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-2)

## CERTIFICATE OF DEATH

06683

Reg. Dist. No. 20

## 1. PLACE OF DEATH:

County Davidsonville  
 City or town Davidsonville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 15 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Davidsonville  
 City or town Davidsonville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Frank L. King

## 3. (b) Social Security Number

216-18-5756

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Alice J. King  
 6.(c) If alive, give age 39 years  
 7. Birth date of deceased (mo., day, yr.) July 8 - 1895  
 8. AGE: Years 50 Months 23 Days hrs. min.

9. Birthplace Davidsonville, Md.  
 (Town, county, and state)  
 10. Usual occupation Farmer  
 11. Industry or business

12. Name Frank L. King  
 13. Birthplace Germany  
 14. Maiden name Louise Ireland  
 15. Birthplace Maryland

16. Informant Alice J. King  
 Address Davidsonville, Md.

17. Burial Date thereof Aug 2/45  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory St. Mary's  
 Location Amnapolis, Md.

18. Funeral director B. I. Hopping  
 Address Amnapolis, Md.

19. August 9, 1945 Registrar  
 (Date received by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30, 1945 at 11:40 p.m.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from h.w. 19 43 to July 30, 1945  
 and that I last saw h.w. alive on July 30, 1945

Immediate cause of death coronary occlusion  
 Due to arteriosclerotic cardiovascular disease  
 Due to \_\_\_\_\_  
 Other conditions varicose veins left leg  
 (Include pregnancy within 8 months of death)

DURATION  
1 1/2 hrs  
8 yrs (2)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE J. Branch W.D. M. D. or other  
 Address Amnapolis, Md. Date signed 7/31/45

RECEIVED  
AUG 9 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

06684



Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundle  
 City or town USNA Annapolis, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State virginia County Roanoke  
 City or town roanoke  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war World War 2 ✓

## 3. (a) FULL NAME

LEWIS, Toney (N) Ser. No. 2667039

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced Single

B. (b) Name of husband or wife (Mother) Mrs. Inez Happer

412-3rd N.E. Roanoke, VA 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) 25 November 1919

8. AGE: Years 25 Months 8 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace virginia  
 (Town, county, and state)

10. Usual occupation US Navy

## 11. Industry or business

12. Name Unknown13. Birthplace Unknown14. Maiden name Unknown15. Birthplace Unknown16. Informant U.S.S. Reina MercedesAddress Annapolis, Maryland17. Removal July 23/45

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory \_\_\_\_\_

Location Lynchburg, VA18. Funeral director Ben L. HoppingAddress 107 West St., Annapolis, Maryland19. July 23 19 45(Date rec'd by registrar) Registrar [Signature]

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 July 19 45 at 1058AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19 \_\_\_\_\_, to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death DROWNING

DURATION

Due to Accidental

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

SIGNATURE H. H. Sadler H. H. SADLER, Lieut. (MC) USNRAddress USS Reina Mercedes M. D. or other 7-20-45

Date signed \_\_\_\_\_

RECEIVED  
JUL 24 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06685



Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Pasadena  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? One year

Hospital, institution, or street address where death occurred:

Mountain Rd.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County City or town Baltimore, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 48 - N. Ellmore St.  
(If rural, give LOCATION)2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

William Russell McKay

## 3. (b) Social Security Number

218-09-8938

## 4. Sex

M

## 5. Color or race

W.

## 6.(a) Single, married, widowed, or divorced

Married

## 6.(b) Name of husband or wife

Lillian White

## 7. Birth date of

deceased (mo., day, yr.)

July 14 - 18826.(c) If alive, give age 61 years

## 8. AGE:

Years

62

Months

11

Days

20

If less than one day

 hrs.  min.

## 9. Birthplace

Baltimore, Md.  
(Town, county, and state)

## 10. Usual occupation

Painter

## 11. Industry or business

Self

## FATHER

12. Name

Wm. S. McKay

13. Birthplace

Baltimore, Md.

MOTHER

14. Maiden name

Estelle McNear

15. Birthplace

Baltimore, Md.

16. Informant

Mr. Lillian Carter (daughter)

Address

Pasadena, Md.

17. (Burial, cremation, or removal) Which?

Burial

Date thereof

July 6, 1945

(month) (day) (year)

Cemetery or crematory

Baltimore

Location

Baltimore, Md.

18. Funeral director

George L. Schuch

Address

101 N. Howard St.

19. (Date rec'd by registrar)

7/4/45

20. Date of death

July 4, 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 22, 1945and that I last saw him alive on 7/3/45

Immediate cause of death

Cerebral thrombosis

Duration

3 days

Due to

metabolic insufficiency

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Estelle D. Pauchest

Address

Baltimore, Md.

Date signed

7/4/45

RECEIVED  
JUL 19 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Green Room, P.O. Pasadena  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? about 30 minutes  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Baltimore, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 339 S. Payson St.  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Robert Lee Metcalfe

## 3. (b) Social Security Number

?

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

M. W. Married.

## 6. (b) Name of husband or wife

Dorothy Metcalfe

7. Birth date of deceased (mo., day, yr.)

April 9 - 19236. (c) If alive, give age 18 years

## 8. AGE:

Years

Months

Days

If less than one day

23311

hrs. min.

## 9. Birthplace

Baltimore, Md.

(Town, county, and state)

## 10. Usual occupation

U.S. Army

## 11. Industry or business

T. Corporal, Md. Postoffice

FATHER

## 12. Name

Charles Metcalfe

## 13. Birthplace

Baltimore, Md.

MOTHER

## 14. Maiden name

Blodys Kales

## 15. Birthplace

Baltimore, Md.

## 16. Informant

John W. Metcalfe (brother)

## Address

Soldier - Unassigned

## 17. Removal

(Burial, cremation, or removal. Which?)

Date thereof July 22, 1945

(month) (day) (year)

## Cemetery or crematory

Heeman Funeral Home

## Location

S. Broadway, Baltimore, Md.

## 18. Funeral director

Howard Blight

## Address

4914 Belair Road, Baltimore, Md.

## 19. 21 July

(Date rec'd by registrar)

19 45

J. A. Crawford Jr.

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 2019 45 at 9:10 P. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...  
 and that I last saw him alive on 19...

## Immediate cause of death

Accidental Drowning

## DURATION

Sudden

## Due to

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes; fill in the following:

Accident, suicide, or homicide accident Date of 7/20/45

Where did injury occur? Green Room - A.C. Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Stoney Creek

Means of injury drowning Injured at work? NO

23. SIGNATURE Robert L. Paulsen, M.D.  
 Address Green Room, Md. M. D. or other

Address Green Room, Md. Date signed 7/20/45

RECEIVED  
JUL 25 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06687

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County June Arundel  
 City or town 34 River Drive, Bay Ridge, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town Washington, D.C.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1819 Kalorama Rd. N.W.  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3.(a) FULL NAME

Elizabeth Margerite Miller

## 3.(b) Social Security Number

## 4. Sex

female

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

W. Clarence Miller

## 7. Birth date of deceased (mo., day, yr.)

March 8, 1882

B.(c) If alive, give age..... years

## 8. AGE:

63

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Hot Springs, Ark.

(Town, county, and state)

## 10. Usual occupation

At Home

## 11. Industry or business

FATHER

## 12. Name

Thomas F. Reilly

## 13. Birthplace

Unknown

MOTHER

## 14. Maiden name

Elizabeth Heller

## 15. Birthplace

Unknown

## 16. Informant

Mrs. A. Reilly

## Address

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

July 18, 1945

## Cemetery or crematory

## Location

## 18. Funeral director

## Address

## 19.

(Date rec'd by registrar)

July 17, 1945

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 15, 1945 at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1945 to July 15, 1945  
 and that I last saw him alive on July 15, 1945

Immediate cause of death

Myocarditis + Myocardial  
 Infarction

DURATION

5 yrs

Due to

Myocarditis5 yrs

Due to

Death of Miller10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED

JUL 19 1945

BUREAU V. S.

## STANDARD CERTIFICATE OF DEATH

State File No. \_\_\_\_\_

Registrar's No. 27State of MARYLAND

## 1. PLACE OF DEATH:

(a) County Anne Arundel  
(b) City or town Ft. George G. Meade,  
(If outside city or town limits, write RURAL)  
(c) Name of hospital or institution:  
Regional Hospital Ft Geo. G. Meade, Md.  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution 5 days  
(Specify whether  
In this community \_\_\_\_\_  
years, months or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Germany (b) County \_\_\_\_\_  
(c) City or town 20 Defreggerstr.  
(If outside city or town limits, write RURAL)  
(d) Street No. #10 Dresden Altsdt  
(If rural, give location)  
(e) If foreign born, how long in U. S. A.? \_\_\_\_\_ years.

3. (a) FULL NAME ARTHUR MUELLER3. (b) If veteran, \_\_\_\_\_ 3. (c) Social Security  
name war \_\_\_\_\_ No. \_\_\_\_\_

4. Sex Male 5. Color or W 6. (a) Single, widowed, married,  
race \_\_\_\_\_ divorced Single  
6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) Age of husband or wife if  
\_\_\_\_\_ alive \_\_\_\_\_ years

7. Birth date of deceased Sept. 15 1904  
(Month) (Day) (Year)8. AGE: Years Months Days If less than one day  
40 10 12 hr. \_\_\_\_\_ min.9. Birthplace Reinhardtsdorf SA Germany  
(City, town, or county) (State or foreign country)10. Usual occupation Mechanic11. Industry or business German Army

MOTHER FATHER { 12. Name \_\_\_\_\_  
13. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)  
14. Maiden name \_\_\_\_\_  
15. Birthplace \_\_\_\_\_  
(City, town, or county) (State or foreign country)

16. (a) Informant's own signature Service Record(b) Address U. S. Army

17. (a) Burial (b) Date thereof 7/28/45  
(Burial, cremation, or removal) (Month) (Day) (Year)  
(c) Place; burial or cremation Post Cemetery, Ft. G.G.  
Meade, Md.

18. (a) Signature of funeral director Howard N. Blight Jr.  
(b) Address 4914 Belair Road

19. (a) 28 July 45 (b) W. J. LAWSON, Jr., 1st Lt.  
(Date received local registrar) (Registrar's signature) MAC.

## MEDICAL CERTIFICATION

20. Date of death: Month July day 27th  
year 1945 hour 10:40 AM minute \_\_\_\_\_21. I hereby certify that I attended the deceased from 23 April 45  
1945, to 27 July, 19 45  
that I last saw him alive on \_\_\_\_\_, 19 45

and that death occurred on the date and hour stated above.

Immediate cause of death  
Liver Cirrhosis

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions  
(Include pregnancy within 8 months of death)Major findings:  
Of operations \_\_\_\_\_Of autopsy confirmed as above.

Duration

PHYSICIAN

Underline  
the cause to  
which death  
should be  
charged sta-  
tistically.

22. If death was due to external causes, fill in the following:

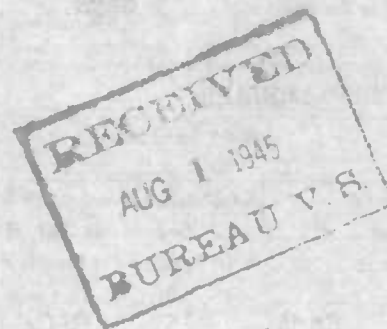
(a) Accident, suicide, or homicide (specify) \_\_\_\_\_

(b) Date of occurrence \_\_\_\_\_

(c) Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)(d) Did injury occur in or about home, on farm, in industrial place, in public  
place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)

23. Signature Arthur A. Free (M. D. or other) \_\_\_\_\_Address Ft Meade, MarylandDate signed 28 Jul



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06689

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Brooklyn - 25  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 1/2 years.  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Brooklyn  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Cedar Hill Lane  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Mugford

## 3. (b) Social Security Number

NONE

## 4. Sex

F.

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Married.

## B. (b) Name of husband or wife

John B. Mugford

## 7. Birth date of deceased (mo., day, yr.)

Nov. 3 - 1860

## 6. (c) If alive, give age

83 years

## 8. AGE:

Years

Months

Days

If less than one day

8482

hrs. min.

## 9. Birthplace

Savonshill, England.  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

John Bristow

## 13. Birthplace

Savonshill, England

## 14. Maiden name

Mary - ?

## 15. Birthplace

Savonshill, England.

## 16. Informant

Mr. J. B. Mugford (husband)

## Address

Brooklyn, W. 25-

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

JULY 7, 1945  
(month) (day) (year)

## Cemetery or crematory

Mount Carmel

## Location

Baltimore, Md

## 18. Funeral director

Thomas W. Dingleton

## Address

Glen Burnie, Md.

## 19.

(Date rec'd by registrar)

19

45Madeline  
Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 5<sup>th</sup>

19

45

at

9:40 p.m.

19

45

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 3<sup>rd</sup>

19

45

to

July 5<sup>th</sup>

19

45

## and that I last saw him

alive on

7/5/45

19

45

## Immediate cause of death

Heart failure

## DURATION

3 days

## Due to

Senility

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Kustave H. Paubert, M.D.

M. D. or other

Address

Glen Burnie, Md

Date signed

7/5/45

RECEIVED

JUL 7 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 29 yrs, 8 mos, 3 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 29 yrs, 8 mos, 3 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County -----  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Bayview Asylum  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ----- ✓

## 3. (a) FULL NAME

PAYNE - MARTHA

## 3. (b) Social Security Number

4. Sex female 5. Color or race black 6. (a) Single, married, widowed, or divorced single  
 6. (b) Name of husband or wife -----  
 6. (c) If alive, give age ----- years  
 7. Birth date of deceased (mo., day, yr.) 1884  
 8. AGE: Years 61 Months unknown Days ----- If less than one day ----- hrs. ----- min.

9. Birthplace Virginia  
 (Town, county, and state)  
 10. Usual occupation Cook  
 11. Industry or business -----  
 FATHER 12. Name G. W. Payne  
 13. Birthplace Virginia  
 MOTHER 14. Maiden name Fannie Lancaster  
 15. Birthplace Virginia  
 16. Informant Hospital Records  
 Address Crownsville, Maryland

17. Burial Date thereof 7/14-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Hospital  
 Location Crownsville  
 18. Funeral director Supr of Hospital  
 Address Crownsville  
 19. 7/14 45 E. Payne Local  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 45 at 4:20P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
October 29 19 15 to July 2 19 45  
 and that I last saw her alive on July 2 19 45

Immediate cause of death Chronic Myocarditis DURATION Apprx. 15 mos.  
 Due to -----  
 Due to -----  
 Other conditions Dementia Praecox Known to us since 10/29/15  
 (Include pregnancy within 3 months of death)

Major findings of operations ----- Date of op. -----  
 Autopsy results -----  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ----- Date of -----  
 Where did injury occur? -----  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) -----  
 Means of injury ----- Injured at work? -----

23. SIGNATURE [Signature] M. D. or other -----  
 Address Crownsville, Maryland Date signed 7/2/45

RECEIVED  
JUL 16 1946  
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of **MARYLAND STATE DEPARTMENT OF HEALTH**  
 2411 N. Charles St., Baltimore **RE**  
**CERTIFICATE OF DEATH**

06691

Reg. Dist. No. 26**1. PLACE OF DEATH:**

County West  
 City or town Princeton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? One week  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State MD County Montgomery  
 City or town Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 216 Wilson Lane  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

**3. (a) FULL NAME**Richard Prescott**3. (b) Social Security Number**4. Sex M 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Feb. 5, 1930 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: 15 Years 5 Months 15 Days 51 If less than one day hrs. min.9. Birthplace Bethesda Md  
(Town, county, and state)10. Usual occupation School11. Industry or business School12. Name R. J. Prescott13. Birthplace Cockville Md14. Maiden name Cecilia J. Kurbach15. Birthplace Toloso Ohio16. Informant R. J. PrescottAddress Bethesda Md17. Requiem (Burial, cremation, or removal, Which?) Date thereof July 20 45  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director Pumphrey Funeral HomeAddress Bethesda Md19. July 20 1945 J. B. Dent  
(Date rec'd by registrar) Registrar**MEDICAL CERTIFICATION**20. DATE OF DEATH July 20 1945 at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_

and that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION

Accidental drowning Sudden

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accident Date of 7-20-45Accident, suicide, or homicideWhere did injury occur? West Prince Georges (City or town) Md (County) (State)Injured at home, farm, industry, public place (where?) ResidenceMeans of injury Accidental drowning23. SIGNATURE Walter H. Hopkins MDAddress Chesapeake Date signed 7-21-45

RECEIVED  
JUL 24 1945  
BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct-age is especially important. Physicians, please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

06692

23

★ Reg. Diat. No. ....

1. PLACE OF DEATH  
 County..... Anne Arundel  
 City or town..... Odenton  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Anne Arundel  
 City or town..... Odenton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME..... Allen Sherman Redmiles  
 3. (b) Social Security Number.....

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Married  
 6.(b) Name of husband or wife..... Lillie E Sears  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... 3-8-75  
 8. AGE: Years..... 70 Months..... -4 Days..... ± If less than one day..... hrs. .... min.

9. Birthplace..... Anne Arundel Co  
 (Town, county, and state)  
 10. Usual occupation..... R. R. Engineer  
 11. Industry or business..... R.F. AND P. DR.  
 12. Name..... Richard S Redmiles  
 13. Birthplace..... Anne Arundel  
 14. Maiden name..... Margaret Courman  
 15. Birthplace..... Maryland  
 16. Informant..... R. Redmiles  
 Address..... Severn R F D

17. BURIAL..... Date thereof..... July 15, 45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... REDMILES ESTATE CEM.  
 Location..... ANNE ARUNDEL COUNTY MD.  
 18. Funeral director..... J. Teckner & Sons  
 Address..... Balto Md

19. July 13 1945..... Caldwell Woodruff  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 12 19..... 45 at..... M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to.....  
 and that I last saw him alive on..... 19.....  
 Immediate cause of death.....

Due to..... Brain Lesion  
Hemiplegia  
 Due to.....  
 Other conditions..... Diabetes Mellitus  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury..... Injured at work?

23. SIGNATURE..... Ednae M. Mear M. D. or other  
 Address..... Millersville Md Date signed..... 7/12/45

REC'D  
AUG 9 1945  
BUREAU V.B.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06693

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County A. A.  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 24 years  
Hospital, institution, or street address where death occurred:  
183 Gloucester St  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A.  
City or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 183 Gloucester  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Robert Redmond

### 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Elizabeth A. Redmond

7. Birth date of deceased (mo., day, yr.) May 3 - 1866 6. (c) If alive, give age 78 years

8. AGE: Years 79 Months 1 Days 2 It less than one day hrs. min.

9. Birthplace Annapolis, Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business

12. Name William Redmond

13. Birthplace Ireland

14. Maiden name Elizabeth Rempsey

15. Birthplace Scotland

16. Informant Elizabeth A. Redmond

Address 183 Gloucester St Annapolis, Md.

17. Burial Date thereof July 8/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Anne's

Location Annapolis, Md.

18. Funeral director B. L. Hopping

Address Annapolis, Md.

19. July 7, 45

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 5 19 45 at 12:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1 19 98 to July 5 19 45

and that I last saw him alive on July 5 19 45

Immediate cause of death Hypertension & Myocardial Infarction

Other conditions Arteriosclerosis

Due to

Due to

Other conditions Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bond

M. D. or other

Address Annapolis, Md.

Date signed 7-7-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

RECEIVED  
JUL 11 1945  
BUREAU V. E.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 4 months, 7 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution? 4 months, 7 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 415 North Carlton Avenue  
 (If rural, give LOCATION)  
unknown  
 2(a) If veteran, name war ☒

## 3. (a) FULL NAME

SCOTT - RICHARD

## 3. (b) Social Security Number

unknown

4. Sex male 5. Color or race black 6. (a) Single, married, widowed, or divorced married  
 6. (b) Name of husband or wife Mary Scott 415 North Carlton, Ave., Baltimore unk. years  
 7. Birth date of deceased (mo., day, yr.) 1882  
 8. AGE: Years 63 Months unknown Days unknown It less than one day --- hrs. --- min.

9. Birthplace unknown  
 (Town, county, and state)  
 10. Usual occupation Laborer  
 11. Industry or business unknown  
 12. Name unknown  
 13. Birthplace unknown  
 14. Maiden name unknown  
 15. Birthplace unknown

16. Informant Hospital Records  
 Address Crownsville, Maryland

17. Buried Date thereof July 24, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Auburn Cemetery  
 Location Baltimore, Maryland

18. Funeral director William A. Jackson  
 Address 916 Penna. Ave., Balto., Md.

19. 7-23 45 E. J. Jones  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 19 45, at 1:30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from March 14 19 45 to July 21 19 45  
 and that I last saw h. im alive on July 21 19 45

Immediate cause of death General Paresis DURATION Known to us since 8/23/45

Due to -----  
 Due to -----  
 Other conditions -----

(Include pregnancy within 8 months of death)  
 Major findings of operations -----

Date of op. -----

Autopsy results -----  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ----- Date of -----  
 Where did injury occur? ----- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----  
 Means of injury ----- Injured at work? -----

23. SIGNATURE E. J. Jones M. D. or other -----  
 Address Crownsville, Maryland Date signed 7/21/45

RECEIVED

JUL 25 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 592

06695

## CERTIFICATE OF DEATH



Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County a aCity or town Wrens Creek  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 years

Hospital, institution, or street address where death occurred:

Wrens Creek

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a aCity or town Wrens Creek  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Ann Sears

## 3. (b) Social Security Number

4. Sex F5. Color or race W6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Edward O. Sears6. (c) If alive, give age 70 years7. Birth date of deceased (mo., day, yr.) Aug 4 - 18968. AGE: Years 68 Months 11 Days 12 If less than one day  
.....hrs. ....min.9. Birthplace Leon, Maryland  
(Town, county, and state)10. Usual occupation Home 1040

## 11. Industry or business

12. Name Esther E. Hill13. Birthplace Maryland14. Maiden name Annie E. Springfield15. Birthplace Maryland16. Informant Bella E. BrierleyAddress Bladensburg, Md.17. Burial Date thereof July 19 / 45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Cedar ValeLocation Annapolis, Md.18. Funeral director P. L. HopkinsAddress Annapolis, Md.19. July 18 19 45  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 16 19 45, at 8 a M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 19 45 to July 16 19 45and that I last saw him alive on July 16 19 45

Immediate cause of death \_\_\_\_\_

DURATION ProneCardio Vascular FailureDue to Cr. Hypertrophic ArteriosclerosisDue to Arteriosclerosis

Other conditions \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. Oliver PurvisAddress Baltimore, Md. M. D. or other 7/16/45  
Date signed

RECEIVED

JUL 19 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (954)

06696

## CERTIFICATE OF DEATH

Reg. Dist. No. 28-

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Anne ArundelCity or town Millersville

(If outside city or town limits, write RURAL and give nearest town)

Street No. Indian Landweg Road

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Agnes Sipniski

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widow

## 6. (b) Name of husband or wife

Martin Sipniski

## 7. Birth date of deceased (mo., day, yr.)

1852

## 6. (c) If alive, give age years

1852

## 8. AGE:

93

Years

Months

Days

If less than one day

hrs.

min.

## 9. Birthplace

Poland

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Farm

## FATHER

## 12. Name

Martin Andrejeski

## 13. Birthplace

Poland

## MOTHER

## 14. Maiden name

Margaret (unknown)

## 15. Birthplace

Poland

## 16. Informant

Cherita Pawlak

## Address

Millersville, Md R.F.D.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

July 5, 1945

## Cemetery or crematory

New Haven Memo (Cm)

## Location

Green Burnie, Md

## 18. Funeral director

Thomas W. Slaughter

## Address

Green Burnie, Md

## 19. Date rec'd by registrar

July 2, 1945E. F. Joyce, Registrar

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

July 2, 194523

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 30, 1945, to July 2, 1945and that I last saw him alive on July 2, 1945

## Immediate cause of death

Chronic myocarditis  
General arterio-  
sclerosis

## DURATION

unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

John M. Caffy, M.D.

M. D. or other

Address

Annapolis, MdDate signed 7/2/45

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED  
JUL 5 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of age is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

## CERTIFICATE OF DEATH

06697

P

Reg. Dist. No. ....

Form No. G 97 AUG 20 1945

### 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Solley  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 36 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? .....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Annapolis  
 City or town Solley Glen Burnie P.O. Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 124th Hill Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

### 3. (a) FULL NAME

Maria C. Smith

### 3. (b) Social Security Number

4. Sex Female 5. Color or race negro 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Charles Smith  
 7. Birth date of deceased (mo., day, yr.) Oct. 8, 1868 6.(c) If alive, give age 72 years  
 8. AGE: Years 76 Months Days If less than one day  
 ....hrs. ....min.

9. Birthplace Solley, Prince Anne's County  
 (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Domestic

12. Name Richard Brady

13. Birthplace Calvert County, Maryland

14. Maiden name Juliana Robbins

15. Birthplace Calvert County, Maryland

16. Informant James R. Edwards

Address Solley, Glen Burnie P.O. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25, 1945

Cemetery or crematory Halls Methodist Ch. A.A. Co.

Location A.A. Co. Md.

18. Funeral director Robert E. Williams

Address 1515 M<sup>c</sup> Elderry St

19. 7125 19 45 (Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 45 at 5:30 A.M.

21. I certify that death occurred on the date above stated. Postmortem Examination

Immediate cause of death Cancer of Stomach DURATION unknown

General Arteriosclerosis unknown

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work? Deputy Medical Examiner

23. SIGNATURE John M. Cluffy M.D. Address Annapolis, Md

Date signed 7-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

06698

★ Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County a aCity or town annapolis  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yearsHospital, institution, or street address where death occurred:  
West St

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a aCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)Street No. 97 West St  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Jacob Snyder

## 3. (b) Social Security Number

4. Sex M5. Color or race W6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Bessie SnyderB. (c) If alive, give age 47 years7. Birth date of deceased (mo., day, yr.) May 10 - 18918. AGE: Years 54 Months 2 Days 12 If less than one day  
.....hrs. ....min.9. Birthplace Russia  
(Town, county, and state)10. Usual occupation Tailor

11. Industry or business

12. Name Hyman Snyder13. Birthplace Russia14. Maiden name Unknown15. Birthplace Unknown16. Informant Bessie SnyderAddress 97 West St Annapolis Md.17. Burial Date thereof July 23/1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Knecht IsraelLocation Three mile oak18. Funeral director B I HoppingAddress Annapolis Md19. July 23 19 45 Wm. French  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 19 45, at 119 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 19 45 to July 22 19 45and that I last saw him alive on July 22 19 45Immediate cause of death Coronary ThrombosisDURATION 1 week

Due to

Due to

Other conditions Benign Prostate Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C BoalAddress Annapolis Md

M. D. or other

Date signed 7 23 45

RECEIVED

JUL 24 1945

BUREAU V.R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06699

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

## 1. PLACE OF DEATH:

County BristolCity or town Bristol  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County aaCity or town Bristol  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Mary Elizabeth Stallings

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Widow8. (b) Name of husband or wife Gorge Stallings1862 2 8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 83 Months 4 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Calvert Co  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Dont know

13. Birthplace

14. Maiden name Dont know

15. Birthplace

16. Informant Ernest CattertonAddress Bristol MD17. Burial Date thereof July 21, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Not givenLocation Laurel Ind.18. Funeral director C. A. Hardy - SonAddress Galesville Md.19. 7/30 45 3rd Plat  
(Date rec'd by registrar) (year) (month) (day)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 19 1945 at 7 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_

and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death Pulmonary Hemorrhage DURATION SuddenDue to Pulmonary Tuberculosis Not Known

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter H. Hyman M.D.Address 1000 Medical Bldg Date signed 7-19-45

RECEIVED  
JUL 25 1945  
BUREAU V. B.

12 1 1  
83  
1862  
1945-7  
82 5 1  
19 61  
49

May 28



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne Arundel  
 City or town Beachwood Grove, Pasadena P.O.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 hour  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2023 East Chase St.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Frank Stancil

## 3. (b) Social Security Number

4. Sex male 5. Color or race negro 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1931

6.(c) If alive, give age years

8. AGE: Years 14 Months Days If less than one day  
 hrs. min.

9. Birthplace Baltimore City, Md.  
(Town, county, and state)10. Usual occupation student11. Industry or business High School12. Name Oscar Stancil13. Birthplace Virginia14. Maiden name Blanche Cornicks15. Birthplace Virginia16. Informant Mrs. Blanche StancilAddress 2023 E. Chase St., Baltimore Md.17. Burial Date thereof Aug 3-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Int Calvary CemeteryLocation A. A. Co. Md.18. Funeral director Robert WilliamsAddress 1515 N. Elderly St.19. 8/1 1945 H.D. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1945 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated, that it was caused by

Postmortem ExaminationJuly 30 1945

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 7-30-45Where did injury occur? near Beachwood Grove P.O., Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Magothy RiverMeans of injury exposed canoe injured at work? noSignature Thos. M. Coffey M.D. Deputy Medical ExaminerAddress Annapolis, Md. Date signed 7-30-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BLA*

## CERTIFICATE OF DEATH

06702

Reg. Dist. No. *21*

## 1. PLACE OF DEATH:

County *Anne Arundel Co*City or town *Annapolis*  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

*39 Franklin St. Street*

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Maryland* County *Anne Arundel Co*City or town *Annapolis*  
(If outside city or town limits, write RURAL and give nearest town)Street No. *39 Franklin St.*  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

*Anna Brenda Steele*

## 3. (b) Social Security Number

4. Sex *Female*5. Color or race *White*6. (a) Single, married, widowed, or divorced *Widowed*6. (b) Name of husband or wife *Norbert Steele*

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) *September 8, 1859*8. AGE: Years *85* Months *10* Days *12* If less than one day  
hrs. min.9. Birthplace *West River A.R. Co. Md.*  
(Town, county, and state)10. Usual occupation *Housewife*

11. Industry or business

FATHER 12. Name *Samuel Steele*13. Birthplace *Prince George Co. Md.*MOTHER 14. Maiden name *Laura E. Hill*15. Birthplace *Prince George Co. Md.*16. Informant *Miss Laura Steele*Address *39 Franklin Street*17. *Burial* Date thereof *July 21, 1945*  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory *St. Ann's Cemetery*Location *Annapolis, Md.*18. Funeral director *Robert M. Taylor*Address *145-149 Duke of Gloucester St.*19. *July 20 45* (Date rec'd by registrar)Registrar *W. J. French*

## MEDICAL CERTIFICATION

20. DATE OF DEATH *July 20 1945* at *1:52* P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *July 4 1945* to *July 20 1945*and that I last saw him alive on *July 20 1945*

Immediate cause of death

*Hypostatic Pneumonia*Due to *fracture of right hip*Due to *accidental fall from a chair**Cr. Prost. Hip Joint*Other conditions *fibrotic heart*

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury *Accidental fall* Injured at work?23. SIGNATURE *Oliver Purvis*Address *Annapolis*Date signed *7/20/45*

RECEIVED

JUL 21 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis  
(If outside city or town limits, write RURAL and give nearest town)How long to above place of death? Six (6) hours

Hospital, institution, or street address where death occurred:

US Naval Hospital Annapolis, Md.How long in hospital or institution? Two and one-half (2½) hrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3723 Hudson  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

HENRY ANDREW STROHMINGER

## 3. (b) Social Security Number

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>

6. (b) Name of husband or wife Effie Strohmingme Voyle 6. (c) If alive, give age 52 years7. Birth date of deceased (mo., day, yr.) May 23, 1892

8. AGE:	Years	Months	Days	If less than one day
	<u>53</u>	<u>1</u>	<u>11</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace Baltimore Maryland  
(Town, county, and state)10. Usual occupation Auto Dealer

11. Industry or business

12. Name George H. Strohming13. Birthplace Balto.14. Maiden name Luzigunda Stinger15. Birthplace Balto.16. Informant Mrs Effie StrohmingAddress 3723 Hudson St.17. Burial Date thereof July 9-45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Eastern Ave. Rd.18. Funeral director John S. ConnollyAddress 4186 Eastern Ave. Comp19. 7/7 85 D. W. Hedrich  
(Date read by registrar) (Year) (Month) (Day) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4 July 1945 19 45, at 2058 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6:30 p.m. 7/24 19 45, to 9 p.m. 7/4 19 45and that I last saw him alive on 7/4 19 45Immediate cause of death Cerebral Hemorrhage DURATION 3 Hrs.Due to Hypertension

Due to

Other conditions Coronary Occlusion

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. G. ... M. D. or otherAddress U.S. Hospital Annapolis Date signed 7-5-45

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF DECEASED

13. SIGNATURE OF DECEASED'S NEAREST RELATIVE

14. SIGNATURE OF DECEASED'S NEAREST RELATIVE

15. SIGNATURE OF DECEASED'S NEAREST RELATIVE

16. SIGNATURE OF DECEASED'S NEAREST RELATIVE

17. SIGNATURE OF DECEASED'S NEAREST RELATIVE

18. SIGNATURE OF DECEASED'S NEAREST RELATIVE

19. SIGNATURE OF DECEASED'S NEAREST RELATIVE

20. SIGNATURE OF DECEASED'S NEAREST RELATIVE

21. SIGNATURE OF DECEASED'S NEAREST RELATIVE

22. SIGNATURE OF DECEASED'S NEAREST RELATIVE

23. SIGNATURE OF DECEASED'S NEAREST RELATIVE

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31. SIGNATURE OF DECEASED'S NEAREST RELATIVE

32. SIGNATURE OF DECEASED'S NEAREST RELATIVE

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39. SIGNATURE OF DECEASED'S NEAREST RELATIVE

40. SIGNATURE OF DECEASED'S NEAREST RELATIVE

41. SIGNATURE OF DECEASED'S NEAREST RELATIVE

42. SIGNATURE OF DECEASED'S NEAREST RELATIVE

43. SIGNATURE OF DECEASED'S NEAREST RELATIVE

44. SIGNATURE OF DECEASED'S NEAREST RELATIVE

3

PLEASE WRITE PLAINLY, WITH **NON-FADING INK**. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Prince GeorgesCity or town near Arundel on the Bay  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. Columbia County WashingtonCity or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1215 - Edgewood St., N.W.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Walter G. Stone

## 3. (b) Social Security Number

4. Sex male5. Color or race white6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Sept 22<sup>nd</sup> 1893

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years Months Days If less than one day

51 9 10 hrs. min.9. Birthplace Frederick Co. Va  
(Town, county, and state)10. Usual occupation Painter

11. Industry or business

FATHER 12. Name William J. Stone13. Birthplace Frederick Co. VaMOTHER 14. Maiden name Sela Verty15. Birthplace Frederick Co. Va16. Informant Mrs. Mary PierreAddress Washington D.C.17. Burial Date thereof July 5<sup>th</sup> 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Gravel Springs Va18. Funeral director Stoner Funeral HomeAddress Strasburg Va19. July 2 19 45 W. Stone  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 19 45 at 10 - 35 M21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~Postmortem Examinationsand that I last saw him alive on 19 \_\_\_\_\_

Immediate cause of death

Coronary Embolism suddenDue to Coronary Sclerosis arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work? no23. SIGNATURE John M. Caffrey M.D. Deputy Medical ExaminerAddress Annapolis Date signed 7/2/45

RECEIVED

JUL 6 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on

FILE No. G 97 JUL 31 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 923

## CERTIFICATE OF DEATH



0670521  
Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Annapolis Md.

City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Emergency Hospital

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 829 West St.

(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Albina Virginia Suite

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Robert F. Suite

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 24<sup>th</sup> 1872

8. AGE: Years 73 Months 71 Days 4 If less than one day 24 hrs. min.

9. Birthplace A A Co Md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name James Baker

13. Birthplace Eastern Shore Md.

14. Maiden name Albina V. Colleson

15. Birthplace Eastern Shore Md.

16. Informant Robert F. Suite

Address 829 West St. Annapolis Md

17. Burial Date thereof July 22<sup>nd</sup> 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Ridge

Location Annapolis Md

18. Funeral director John M. Taylor

Address Annapolis Md

19. July 20 45 Wm. J. Munch  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 18 19 45, at 5:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 15 19 45, to July 18 19 45

and that I last saw him alive on July 18 19 45

Immediate cause of death

Myocardial infarction

Due to

arteriosclerosis

Due to

cholesterol

Other conditions cholesterol

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Boul

Address Annapolis Md

Date signed 7-20-45

M. D. or other

RECEIVED

JUL 21 1945

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 832

## CERTIFICATE OF DEATH

 06706 20  
 ★ Reg. Dist. No.

## 1. PLACE OF DEATH

 County San Haven  
 City or town San Haven  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Laurel Joyce Taylor

## 3. (b) Social Security Number

None
4. Sex M 5. Color or race C 6. (a) Single, married, widowed, or divorced W6. (b) Name of husband or wife Bertie Taylor
 7. Birth date of deceased (mo., day, yr.) Nov. 27, 1872 6. (c) If alive, give age 60 years

 8. AGE: Years 72 Months 7 Days 18 If less than one day hrs. min.

 9. Birthplace A. A. Co. Va.  
 (Town, county, and state)
10. Usual occupation Widow

11. Industry or business

12. Name Laurel Taylor13. Birthplace Va.14. Maiden name Laurel Taylor15. Birthplace Va.16. Informant Laurel TaylorAddress San Haven, Md.
 17. Burial Date thereof 7/18/45  
 (Burial, cremation, or removal—Which?) (month) (day) (year)
Cemetery or crematory Grundy'sLocation Grundy's18. Funeral director W. A. Anderson & SonAddress San Haven, Md.
 19. 7/17/45  
 (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County San Haven
 City or town San Haven  
 (If outside city or town limits, write RURAL and give nearest town)

 Street No. San Haven  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH 7/15 1945, at 6:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

7/13 1945, to 7/15 1945

 and that I last saw him alive on 7/14 1945

Immediate cause of death

Cerebral hemorrhage

DURATION

2 hrs.

One to

One to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. A. Anderson

M. D. or other

 Address San Haven, Md. Date signed 7/17/45

RECEIVED  
JUL 20 1945  
BUREAU V. S.

Lower third of the

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(462)

## CERTIFICATE OF DEATH



Reg. Dist. No.

26

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

4. Sex

5. Color &amp; race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

It less than one day

..... hrs. .... min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.....  
(Burial, cremation, or removal. Which?)Date thereof.....  
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. July 18 1945  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 16 1945 at 9:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/29 1945 to 7/16 1945  
and that I last saw him alive on 7/16/45 1945

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address: 35 Andrews St. Date signed: 7/27/45



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (158)

06708

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:  
 County..... Anne Arundel Co.  
 City or town..... Annapolis Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 12 days  
 Hospital, institution, or street address where death occurred:  
 206 Clay St.  
 How long in hospital or institution?..... \*\*\*\*\*

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Maryland County Anne Arundel  
 City or town..... Annapolis Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 206 Clay St., Annapolis Md.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... \*\*\*\*\*

## 3. (a) FULL NAME

Ronald Thompson

## 3. (b) Social Security Number

None

4. Sex..... Male  
 5. Color or race..... Col.  
 6.(a) Single, married, widowed, or divorced..... \*\*\*\*-  
 6.(b) Name of husband or wife..... \*\*\*\*\*  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... July 12, 1945  
 8. AGE: Years Months Days If less than one day  
 1 1/2 ..... hrs. .... min.

9. Birthplace..... Annapolis Md. A. A. Co.  
 (Town, county, and state)  
 10. Usual occupation..... \*\*\*\*\*  
 11. Industry or business..... \*\*\*\*\*

12. Name..... James Thompson  
 13. Birthplace..... Alabama  
 14. Maiden name..... Nellie Boggs  
 15. Birthplace..... Annapolis Md.

16. Informant..... Nellie Boggs  
 Address..... 206 Clay St. Annapolis Md.  
 17. Burial Date thereof..... 7 /16/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... St. Mary's Cemetery  
 Location..... West St. ex'd. Annapolis Md.

18. Funeral director..... Mrs Chas. E. Hicks  
 Address..... 45 Northwest St. Annapolis Md.

19. July 16 19 45 7/16/45  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 7/14 19 45 at 6 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/13 19 45 to 7/14 19 45  
 and that I last saw h. alive on 7/14/45  
 Immediate cause of death..... Marasmus State  
 DURATION 2 day  
 Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....

23. SIGNATURE..... J. H. Thompson M.D.  
 Address..... 35 Northwest St. Date signed 7/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 17 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

66709

P

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Linthicum Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 23 years  
 Hospital, institution, or street address where death occurred:

Now long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Anne Arundel  
 City or town Linthicum Heights  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hilltop  
 (If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Russ Donnelly Tolson

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife

late Ernest E.

7. Birth date of deceased (mo., day, yr.)

Apr. 7, 1870

8.(c) If alive, give age .....

8. AGE:

Years

Months

Days

If less than one day

75314

hrs.

min.

9. Birthplace

Baltimore City, Maryland  
(Town, county, and state)

10. Usual occupation

retired

11. Industry or business

housewife

FATHER

12. Name

Michael Donnelly

13. Birthplace

Baltimore, Md

MOTHER

14. Maiden name

Russ

15. Birthplace

Baltimore Md

16. Informant

Marie F. Tolson

Address

Hilltop, Linthicum Heights Md

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

New Cathedral

Location

Balto. Md

18. Funeral director

Harry J. Witzke

Address

4101 Edmonson dr

19.

(Date rec'd by registrar)

19

July 21, 1945

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 21, 1945 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Postmortem Examination

and that I last saw him on

July 21, 1945

Immediate cause of death

Acute Dilatation of Heart

DURATION

Sudden

Due to

Chronic myocarditisunknown

Due to

Arterio-sclerosisunknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed

7-21-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (848)

## CERTIFICATE OF DEATH

Reg. Dist. No. 28

## 1. PLACE OF DEATH:

County..... Anne Arundel County  
 City or town..... Crownsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 4 days  
 Hospital, institution, or street address where death occurred:  
Crownsville State Hospital  
 How long in hospital or institution?..... 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County.....  
 City or town..... Baltimore City  
 (If outside city or town limits, write RURAL and give nearest town)  
unknown  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

WALKER - MARY

## 3. (b) Social Security Number

unknown

4. Sex..... female  
 5. Color or race..... black  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... James Walker  
 6.(c) If alive, give age..... unk. years  
 7. Birth date of deceased (mo., day, yr.)..... 1909  
 8. AGE: Years..... 36 Months..... unknown Days..... If less than one day..... hrs. .... min.

9. Birthplace..... unknown  
 (Town, county, and state)  
 10. Usual occupation..... Domestic  
 11. Industry or business.....  
 12. Name..... unknown  
 13. Birthplace..... unknown  
 14. Maiden name..... unknown  
 15. Birthplace.....

16. Informant..... Hospital Records  
 Address..... Crownsville, Maryland  
 17. Burial..... Burial Date thereof..... 7 / 31 / 45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Fairlee Cemetery  
 Location..... Butlertown Md.  
 18. Funeral director..... Wm Marvin V. Williams  
 Address..... Chestertown Md.  
 19. Date rec'd by Registrar..... July 29 45 Registrar.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 26 19..... 45, at..... 2 P M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... July 22 19..... 45 to..... July 26 19..... 45  
 and that I last saw h..... or alive on..... July 26 19..... 45

Immediate cause of death..... schizophrenic Exhaustion  
 DURATION..... Known to us since 7/22/45  
 Due to.....  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?.....  
 23. SIGNATURE..... Wm Marvin V. Williams M. D. or other  
Crownsville, Maryland Date signed..... 7/26/45

# 9370

Walker p Mary  
Baltimore City  
Admitted - July 22, 1945  
Died - July 26, 1945

RECEIVED

AUG 8 1945

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06711

Reg. Dist. No. 21

### 1. PLACE OF DEATH:

County Anne Arundel  
City or town Annapolis Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
City or town Eastport  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Chesapeake Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Amy Viola Warfield

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife Bernard Warfield

7. Birth date of deceased (mo., day, yr.) Oct 20<sup>th</sup> 1882 6. (c) If alive, give age 45 years

8. AGE: Years 62 Months 8 Days 19 If less than one day hrs. min.

9. Birthplace Baltimore Co. Md.  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name John S. Meek

13. Birthplace Maryland

14. Maiden name Josephine Beasley

15. Birthplace Maryland

16. Informant Mrs. Dorothy W. Lamb

Address 827 Chesapeake Ave Eastport Md

17. Burial July 10<sup>th</sup> 1945

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Friendship Cemetery

Location M. Dorsey Co. & N. Pl.

18. Funeral director John W. Layler

Address Annapolis Md.

19. July 10 19 45

(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH July 8 19 45 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 19 45 to July 8 19 45 and that I last saw him alive on July 8 19 45

Immediate cause of death Arteriosclerosis of heart DURATION unknown

Due to

Due to

Other conditions Arteriosclerosis Myocardial infarction

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Bail M. D. or other

Address Annapolis Md Date signed 7-10-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUL 11 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

06712 20  
Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County..... Anne Arundel Co./  
 City or town..... Edgewater Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 years  
 Hospital, institution, or street address where death occurred:  
Edgewater Md.  
 How long in hospital or institution? \*\*\*\*\*

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Anne Arundel Co.  
 City or town..... Edgewater Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... None  
 (If rural, give LOCATION)  
 \*\*\*\*\*  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Elizabeth Watkins

## 3. (b) Social Security Number

None

4. Sex..... Female  
 5. Color or race..... Col.  
 6.(a) Single, married, widowed, or divorced..... Single

6.(b) Name of husband or wife..... \*\*\*\*\*

B.(c) If alive, give age..... \*\*\*\*\* years

7. Birth date of deceased (mo., day, yr.) September 5, 1909

8. AGE: Years..... 35 Months..... 35 Days..... 10 If less than one day..... hrs. .... min.  
2

9. Birthplace..... Annapolis Md. A. A. Co  
(Town, county, and state)10. Usual occupation..... Maid11. Industry or business..... None12. Name..... Samuel Watkins13. Birthplace..... Annapolis Md.14. Maiden name..... Elnora Colbert15. Birthplace..... Annapolis Md.18. Informant..... Mary Watkins HebronAddress..... 21 Obrine Court Annapolis Md.17. Burial Date thereof..... July 10 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Brew Hill CemeteryLocation..... West St Extd.18. Funeral director..... Mrs Charles E. HicksAddress..... 45 Northwest St. Annapolis Md.19. July 9 1945 Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... July 7 1945 at..... 12:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... July 6 1945 to..... July 7 1945and that I last saw him..... alive on..... July 7 1945Immediate cause of death..... Acute Cardiac Dilatation

DURATION

Due to..... Chronic MyocarditisDue to..... Spontaneous

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

Other conditions.....

PROBIVMD  
JUL 12 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 183

## CERTIFICATE OF DEATH

06713

Reg. Diet. No. 21

## 1. PLACE OF DEATH:

County... Ann ArundelCity or town... St. Margarets  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... AnnapolisCity or town... Arnold  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

David Watts

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Colored

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Aug. 27, 1927

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

1710

.....hrs. ....min.

9. Birthplace

Arnold, Md.

(Town, county, and state)

10. Usual occupation

Laborer

11. Industry or business

FATHER

12. Name

Samuel Watts

13. Birthplace

Arnold, Md.

MOTHER

14. Maiden name

Alverta Gray

15. Birthplace

Calvert Co.

16. Informant

Samuel Watts

Address

Arnold, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof... July 8, 1945  
(month) (day) (year)

Cemetery or crematory

Mt. Calvary

Location

Arnold, Md.

18. Funeral director

J.B. Johnson.

Address

Annapolis, Md.

19.

July 7 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

July 4 1945 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated, and I attributed death to

Post mortem Examination  
..... alive on ..... 19.....

Immediate cause of death

Accidental Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes fill in the following:

Accident, suicide, or homicide

Accident

Date of

7-4-45

Where did injury occur?

near Annapolis R.D., Md.

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Mill Creek

Means of injury

Drowning

Injured at work?

No

23. SIGNATURE

John M. Caffey M.D.  
Annapolis Md.

M. D. O.

Date signed

7-7-45

WESTLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
JUL 11 1945  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93A

## CERTIFICATE OF DEATH

06714  
★ Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Annapolis Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 75 Shipwright St  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Edwin M. S. Wild

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ellenore C Wild

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

July 21<sup>st</sup> 1871

8. AGE:

74

Years

Months

Days

If less than one day

7

hrs.

min.

9. Birthplace

Baltimore Md  
(Town, county, and state)

10. Usual occupation

Ret. Stone Mason U.S.N.

11. Industry or business

Academy Annapolis Md

FATHER

12. Name

John Wild

13. Birthplace

Baltimore Md

MOTHER

14. Maiden name

Wickerson

15. Birthplace

Wickerson

16. Informant

Mrs Ellenore C Wild

Address

75 Shipwright St. Annapolis Md17. Burial  
(Burial, cremation, or removal. Which?)Date thereof July 31<sup>st</sup> 1945  
(month) (day) (year)

Cemetery or crematory

Cedar Bluff

Location

Annapolis Md

18. Funeral director

John M. Taylor

Address

Annapolis Md19. July 30 45  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 19 45 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 1 19 45 to July 28 19 45and that I last saw him alive on July 27 19 45

Immediate cause of death

Myocardial infarction

DURATION

Chc.

Due to

Due to

Other conditions

Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George C. Boul

M. D. or other

Address

Annapolis MdDate signed 7-29-45

RECEIVED  
JUL 31 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

06715

Reg. Dist. No. 21

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Edgewater  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County H. A. CarCity or town Edgewater  
(If outside city or town limits, write RURAL and give nearest town)Street No. Edgewater Beach  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Edward C. Wilson M.D.

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Kathleen Wilson

## 7. Birth date of

deceased (mo., day, yr.)

April 8, 1880

6. (c) If alive, give age years

## 8. AGE:

Years

Months

Days

If less than one day

6535

hrs.

min.

## 9. Birthplace

New York Mills, N.Y.

(Town, county, and state)

## 10. Usual occupation

Physician

## 11. Industry or business

Self-employed

## FATHER

## 12. Name

Charles Wilson

## 13. Birthplace

New York Mills, N.Y.

## MOTHER

## 14. Maiden name

Chris Conklin

## 15. Birthplace

Williamstown, N.Y.

## 16. Informant

Charles Wilson

## Address

Edge Water BeachBurial

## 17.

(Burial, cremation, or removal. Which?)

Date thereof

July 14, 1945  
(month) (day) (year)

## Cemetery or crematory

Eden Hills

## Location

Not

## 18. Funeral director

Martha W. DeLong

## Address

1300 N. St. Ave

## 19.

(Date rec'd by registrar)

July 11, 1945

Registrar

## 23. SIGNATURE

Edith Rodler M.D.

M. D. or other

## Address

42 State CircleDate signed 7-11-45

## MEDICAL CERTIFICATION

20. DATE OF DEATH Edgewater 7-11, 1945 at 9:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

on July 11, 1945 to 1945and that I last saw him alive on July 11, 1945

Immediate cause of death

pulmonary

DURATION

12 years

Due to

coronary heart disease

Due to

aortic atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

RECEIVED  
JUL 12 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

06716

27

## 1. PLACE OF DEATH:

County Anne ArundelCity or town Ft. Geo. G. Meade, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Regional Hospital

How long in hospital or institution?

2 hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Epfenbach County beiCity or town Heidelberg, Germany

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war. ....

## 3. (a) FULL NAME

Gustav ZIEGLER

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

B. (c) If alive, give age ..... years

## 7. Birth date of

deceased (mo., day, yr.)

November 18, 1923

## 8. AGE:

Years

Months

Days

If less than one day

217 mos.21

..... hrs. .... min.

9. Birthplace Epfenbach-bei-Heidelberg, Germany

(Town, county, and state)

## 10. Usual occupation

Prisoner of War

## 11. Industry or business

FATHER  
MOTHER

## 12. Name

Gustav Zeigler

## 13. Birthplace

Unknown

## 14. Maiden name

Unknown

## 15. Birthplace

Unknown

## 16. Informant

PW Records

Address

U. S. Army

## 17.

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Post Cemetery

Location

Ft. Geo. G. Meade, Md.

## 18. Funeral director

Howard Blight

Address

4914 Belair Road, Baltimore, Md.

## 19.

(Date rec'd by registrar)

July 9,1945W. J. LAWSON, JR.,

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH July 7, 1945 at 5:10 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased on  
July 7, 1945 X X Xand that I last saw him in alive on July 7, 1945Immediate cause of death Subarchnoid hemorrhage, DURATIONsevere. 2. Laceration of brain.3. Skull fracture occipital, severe

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 7, 1945Where did injury occur? Woodbine Maryland  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) FarmMeans of injury Fell from truck Injured at work? Yes

## 23. SIGNATURE

S. D. Hooper, Jr.  
Reg Hosp Ft Meade Md

M. D. or other

July 8/45

Date signed

1st Lt., MAC

RECEIVED  
JUL 13 1945  
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Ed* *BA*

## CERTIFICATE OF DEATH

Reg. Dist. No. *4*

## 1. PLACE OF DEATH:

County

City or town

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infant, give residence of mother)

State

County

City or town

Street No.

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

M. D. or other

Date signed